PRINTED: 04/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155727  NAME OF PROVIDER OR SUPPLIER  STONEBRIDGE HEALTH CAMPUS		A. BUILDING COI		(X3) DATE SURVEY COMPLETED 03/16/2011	
STONEB	RIDGE HEALTH C	AMPUS	BEDFO	DRD, IN47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	State Licensure the Investigation IN00087611.  Complaint IN00 Federal/State de allegations are consumption of the state of	087611 substantiated. ficiencies related to the ited at F371 and R272. farch 14, 15 and 16, 2011 fice 003924 fice 155727 foot4472040  RN TC  RN fin RN fin RN  fice related to the ited at F371 and R272.  RN fin RN fin RN  fin RN  fine related to the ited at F371 and R272.  RN fine related to the ited at F371 and R272.  Race of the ited at F371 and R272.	F0000	The submission of this plan correction does not indicate admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality care provided to the resident of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medicall necessary care and services its residents in an economic and efficient manner. The facility herby maintains it is substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management this facility. It is thus submitted as a matter of state only.	of tts  y s to in  h of tue
LABORATOR	Y DIRECTOR'S OR PRO'	VIDER/SUPPLIER REPRESENTATIVE'S SIC	SNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9KYF11

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727		A BUILDING			(X3) DATE : COMPL 03/16/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	IDDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH RD, IN47421		
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	Sample: 11 Supplemental san	mple: 2					
These deficiencies also reflect state findings in accordance with 410 IAC 16.2.							
	Quality review completed 3-20-11 Cathy Emswiller RN						

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	Cathy Emswiller	Cathy Emswiller RN				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155727 03/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3100 SHAWNEE DR SOUTH STONEBRIDGE HEALTH CAMPUS BEDFORD, IN47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident # 22 no longer resides F0315 Based on observation, interview, and F0315 04/12/2011 in this campus. Completion Date record review, the facility failed ensure a SS=D 4-12-2011All residents have the resident who had a catheter was provided potential to be affected by the services to prevent urinary tract alleged deficient practice and therefore through corrective infections, in that Resident #22 actions and in servicing the experienced having a Foley catheter campus will ensure residents who drainage bag and tubing held above the have a foley catheter receive level of the bladder, for 1 of 1 residents appropriate treatment and reviewed for Foley catheters in the sample services to prevent urinary tract infections.Completion Date of 11. 4-12-2011All nursing staff has been in serviced on proper care Findings include: of a foley catheter. Systemic change care givers will complete a competency "care of resident Resident 22 was identified on the initial with a foley catheter" now and tour of the facility on 3/14/11, at 9:15 annually thereafter. Completion A.M., by the Medical Records Nurse, as Date 4-12-2011DHS and/or designee will monitor compliance having a Foley catheter, requiring with observation of care audits on assistance with activities of daily living, 2 residents per day with a foley and being cognitively impaired. catheter 5x a week x one month then weekly thereafterwith results The resident was observed on 3/14/11 at forwarded to the QA committee for 6 months and quarterly 9:15 A.M., lying in bed and had a Foley thereafter for further review and catheter. suggestions/recommendations. Completion Date 4-12-2011 The clinical record of Resident 22 was reviewed on 3/14/11 at 12:35 P.M. The Resident's diagnoses included, but were not limited to, Urinary Tract Infection and Urinary Retention with outlet obstruction. The admission MDS (minimum data set) assessment, dated 2/13/11, indicated the

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	urine, required a	quently incontinent of ssistance with activities and was cognitively			
	indicated the rest breakdown due t and foley cathete but were not lim	lem, dated 2/14/11, ident was at risk for skin o urinary incontinence er. Approaches included, ited to, "maintain ow the level of bladder."			
	2/16/11 indicated ordered for the d	sicians order dated  d a Foley catheter was  iagnosis of Urinary  ladder obstruction.			
	Practical Nurse] Nursing Assistan assist Resident # the bed. CNA #1	:15 P.M., LPN [Licensed #1 and CNA [Certified at] #1 was observed to 22 from the wheelchair to was holding the Foley ft hand above the level of			
	observed to place drainage bag on folded blankets a	:20 P.M., CNA #1 was e the Foley catheter top of a pillow and two at foot of the bed allowing to be above the level of			
	On 03/15/11 at 1	:23 P.M. CNA #1 was			

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	tubing by holding abdomen of Resi	the Foley catheter g the tubing up over the dent #22 allowing the allow the level of the					
		:24 P.M. LPN #1 was CNA #1, "I wouldn't have					
	On 03/15/11 at 1:26 P.M. CNA #1 was observed to lay the Foley catheter tubing on the bed and the tubing was observed to immediately fill with urine.						
	provided by the I Nursing] on 03/1 indicated, "Gene Guidelines 1. O	**					
	[Director of Nurs 10:00 A.M., she policy for keepin tubing and drains	iew with the DoN sing] on 03/16/11 at indicated, "there is no g the foley catheter age bag below the level ey just follow the CNA guidelines."					

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	Core Curriculum dated July 1998, CNA's should: a below level of biflow e. Consider system whenever resident."  During an interver 03/15/11 at 3:35 important to kee below the level of doesn't go back in the CNA's wouldn't want it the CNA's wouldn't want it the CNA's would CNA's] pants, but During an interver [Director of Nural A.M., she indicated by the control of the control	iew with LPN #1 on P.M. she indicated, should not be so high, I to flow back. Normally d hook it on their [the at she was nervous."  iew with the DoN sing] on 03/16/11 at 9:45 ted, "The tubing and ould never be above the				

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F0371 SS=F	Based on observarecord review, the food was prepared conditions, for 1 the facility, in the follow the policy monitoring food temperatures to earn foods served their hands were dirty dishes and staff of clean the juice dispotential to affect who reside within units and receive Resident A, B are Findings included.  1. During the info on 3/14/11 at 9:0 was observed rurthed dishwasher, dishwasher used dishes. She furth temperature should during the rinse of silverware in the had a temperature rinse cycle, the conditions of the cond	ation, interview and e facility failed to ensure d and served in sanitary of 1 kitchens observed in at the facility failed to and procedure for and dishwasher usure the safety of dishes staff failed to ensure washed after handling before touching clean lid not know how to spenser. This had the t all 42 of 42 residents the facilities certified food from the kitchen. and C  itial tour of the kitchen of A.M. Dietary Staff #1, uning dirty dishes through She indicated the hot water to sanitize the the indicated the lid reach 180 degrees eycle. The load of dishwasher at 9:00 A.M. the of 166 degrees on the tycle was repeated with	F03		Resident A, B, and C, suffered ill effects from the alleged deficient practice. Completion Date 4-12-2011All other reside have the potential to be affected by the deficient practice and through alterations in processe and in servicing will ensure the campus prepares food and serves food in sanitary conditions. Completion Date 4-12-2011Dietary staff has been in serviced concerning the chemical sanitizer on the dish washing machine, hand washing cleaning of the juice machine, food temperatures/thermomete calibration and log book recording. systemic change the dish machine has been fitted washing competency now and annually thereafter. A cleaning log has been inititated to track daily cleaning ofthe juice machine, an dietary staff #2 is longer a cook. Completion Date 4-12-2011DFS/designee will monitor daily log book for chemical sanitation, food temperatures and juice machine cleaning log to assure in compliance. DFS/designee will also observe two random dieta staff preparing food or washing dishes to assure sanitation guidelines followed. These au will be complete 5x a week for month then 3x week for a mon	ents ed es en ng, er e vith g the no e dits a	DATE 04/12/2011
	me temperature (	of the rinse cycle reaching			then weekly with results		

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TAG	174 degrees. The removed and plates was then p with the rinse tendegrees. The plates observed to be statistichen.  The maintenance kitchen at 9:10 A mixing valve on on order and had temperatures. He the temperatures had been instruct between loads to temperature reaction.  Dietary staff #1 v provided a log of dishwasher, labe on 3/14/11 at 9:1 areas for food termeals and dishwathree meals. The areas for sanitize sink and cleaning.  The form for 3/1 documented rinse degrees. The log 3/13/11, indicate and sand cleaning.	e silverware was ced to dry. A load of laced in the dishwasher inperature reaching 174 tes and silverware were ored for future use in the  supervisor entered theM. and indicated a the hot water heater was been causing the low e indicated he checked each morning and staff ed to wait a few minutes ensure the rinse hed 180 degrees.  was asked for and femperatures of the led "Daily Data Sheet," 5 A.M. The form had imperatures for all three asher temperatures for all back of the form had r concentration in the g bucket.		TAG	forwarded to QA committee monthly x 6 months and quart thereafter for review and furth suggestions/comments.Comp n Date 4-12-2011	erly er	DATE

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	breakfast temper with a rinse temperature for 3/2 and 3/5 were contemperatures 180 3/6/11 document lunch temperature temperatures were 3/8. 3/9/11- lacked lunch or supper to breakfast rinse were degrees, 3/12/11 degrees for the risother temperature or supper from 3/2 documented the 1/180 degrees for the documentation were supper.  The February 20 temperature log in days that were predocumented rinse 1/80 degrees, 11 or provided had at 1/180 degrees degr	ature was documented berature of 175 degrees, or 3/3 were provided, 3/4 inplete with all rinse degrees or above, ed the breakfast and re as 200 degrees, supper re not documented, 3/7, ed documentation of emperatures, 3/10 ras documented at 178 rakfast rinse was 179 breakfast was 168 inse temperature, with no res documented for lunch range of the rinse, no ras completed for lunch range of the rinse, no ras completed for lunch range of the rinse, no range of the 24 range of the 24					

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	RIDGE HEALTH CA			BEDFO	RD, IN47421		
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1710		sanitizer concentration		1/10			DATE
	_	y recorded to ensure					
	proper sanitation of dishes and utensils,"						
	^ ^	nachine temperatures and					
		ration will be recorded					
		wash or rinse cycles					
		not meet the minimum					
	requirements, the	e dining services manager					
	will be notified	if the temperatures do					
	not meet requirements, the cycle will be repeated and temperatures observed. If						
		not meet standards,					
		will be takendish					
	_	ture andlogs and					
	· · · · · · · · · · · · · · · · · · ·	orrective action will be					
	kept on file"						
	The dishwasher i	nanufactures product					
	information was	provided on 3/16/11 at					
	10:00 A.M. by th	ne maintenance					
	supervisor, the po	olicy indicated the					
	temperature for t	he rinse cycle should be					
	180 degrees to 19	90 degrees for hot water					
	sanitation to occu	ır.					
	2. Dietary staff	#3 was observed on					
		.M. with a load of dishes					
	in the dishwasher	r. Dietary staff #3					
		perature of the rinse					
	cycle was reaching	ng "almost 180." The					
	load of plates in	the dishwasher was					
	observed to have	a wash temperature of					
	156 degrees and	a final rinse temperature					

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	PROVIDER OR SUPPLIER			3100 SH	DDRESS, CITY, STATE, ZIP CODE  HAWNEE DR SOUTH  RD, IN47421			
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	•	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B			COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATÉ.	DATE	
	of 172 degrees, the	he plates were placed on						
	the drying rack.	Dietary staff #3 was						
	observed to rinse	dirty dishes, with no						
	gloves or gown o	on, touching the dirty rack						
	and dishes with h	ner hands and uniform						
	front. She was th	nen observed to go take						
	-	and put them away.						
	<del>-</del>	was not observed to wash						
		en handling the dirty						
	dishes and then the clean dishes while putting them away in the kitchen. Dietary							
	staff #3 then washed her hands, handled							
		placing them in racks and						
	_	sher, she then went to the						
		dishwashing area,						
		shes and put them in						
	-	e use in the kitchen.						
		was not observed to wash						
		en handling the dirty						
	dishes and the cle	ean dishes.						
	The policy and p	rocedure for						
		date, was received by						
	_	tary support person, on						
	3/16/11 at 10:45							
		se proper hand washing						
	techniques to pre							
	• •	nds are washed when						
	entering the Nutr							
	_	er handling soiled dishes						
	and utensils"	a nanding solice distics						
	3. The facility w	as observed to have a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING				(X3) DATE SURVEY COMPLETED 03/16/2011	
			B. WIN		DDRESS, CITY, STATE, ZIF	_	
NAME OF I	PROVIDER OR SUPPLIEF	2		1	HAWNEE DR SOUTH		
STONEB	RIDGE HEALTH CA	AMPUS		1	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF O		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEI ICIENCI I	,	DATE
	1 * .	n the dining room on					
3/14/11 at 9:00 A.M. Dietary staff #2 and #1, on 3/14/11 at 10:00 A.M. indicated							
	l '	re cleaned on the top and					
		ning shift aide, and					
	1 *	ny came in and cleaned					
		staff # 4 indicated on					
	1	P.M. the evening shift					
		e machines. Dietary staff					
		nide, was interviewed on					
	'	o.m. indicated she washed					
	the top of the machine, the drainage tray						
	was brought into the kitchen and washed,						
		shed down with the ends					
	of the tubes whe	re juice flowed down					
	from the box wip						
	The Cleaning an	d Preventative					
	Maintenance pol	icy provided on 3/15/11					
	at 10:00 A.M. by	the Facility					
	administrator. T	he policy indicated it had					
		e facility on 3/14/11 at					
	10:27 A.M. The	policy indicated "daily:					
	^ ~	. Remove and wash the					
	_	, mixing elements, drip					
		y cover in a mild					
	_	n, rinse thoroughly. 2.					
		el, areas around dispense					
		igerated compartment					
	with a clean, dan	np cloth."					
	During interview	with the Dining Services					
	_	ee, acting as the dietary					
	Support employe	e, acting as the dictary					
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155727		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/16/2011		
		100727	B. WIN		DDDEGG CITY OFFEE ZW CODE	03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	RIDGE HEALTH CA		BEDFORD, IN47421				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		5/11 at 10:00 A.M., he					
	indicated there was no documentation of						
		ng cleaned the machine.					
	1	had taken the machine					
	apart the day bef	ore and cleaned it. He					
	^	the company who					
		chine serviced the					
	machine. The fa	cility administrator					
	provided service	records on 3/15/11 at					
	1:30 p.m. which	indicated juice dispenser					
	was serviced once each month, with the last service date of 2/25/11.						
	3. During the grat 9:15 A.M. 2 or Resident A and Emeeting indicated chicken that appearence with the Resident C on 3/indicated Resident C on 3/indic	oup meeting on 3/15/11					

NAME OF PROVIDER OR SUPPLIER  STONEBRIDGE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  (X4) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COM-	(X3) DATE SURVEY COMPLETED 03/16/2011	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  not allow her family member to consume  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMBRIGHT TO THE APPROPRIATE DEFICIENCY		
	(X5) COMPLETION DATE	
The week-end manager, LPN #5, the manager of the residential part of the facility, was interviewed on 3/14/11 at 1:00 P.M. She indicated the chicken served at approximately 5 P.M. at the Saturday evening on the hall trays appeared undercooked. She indicated she immediately stopped the chicken from being served to residents throughout the facility and provided replacements. LPN #5 indicated she and LPN #6 then checked the chicken on the steam tables for the dining rooms, she indicated the chicken on those lines appeared done and was then served out. During interview with LPN #6 on 3/16/11 at 10:30 A.M. she indicated she had pulled the chicken from all hall trays and provided replacements, this included the one pureed tray on the hall. LPN #6 indicated she checked all chicken on the buffet in the dining rooms and it appeared to be done. LPN #6 indicated she at a piece to check and all seemed fine with it. LPN #6 indicated she did not know if a temperature had been obtained.  Dietary staff # 2 was interviewed on 3/15/11 at 9:00 A.M. she indicated the chicken had looked completely cooked to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or correction	155727	A. BUILDING		03/16/2011	
			B. WING	TADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		l	SHAWNEE DR SOUTH		
	RIDGE HEALTH CA		BEDF	ORD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
1110	her. She indicate		1716		DATE	
		could not remember what				
	it was and did not record the temperature.					
		ndicated she had used				
	-	ken to make the purred				
		peared to be done.				
	_	ndicated the past dietary				
		n training her for two				
	•	a cook before she worked				
	as the cook on 3/					
	The Corporate di	etary services support				
	person indicated	on 3/15/11 at 10:00				
	A.M., he had bee	en called about the				
	chicken and arriv	ved back at the facility on				
	Sunday at 7:00 A	.M. He further indicated				
	he had changed t	he schedule to ensure				
	only staff trained	as cooks were cooking.				
	He indicated Die	tary staff #2 had not been				
	trained to cook in	n the facility but was				
	trained as a dieta	ry aide to assist the cook.				
	Dietary staff #2's	employee file was				
		5/11 at 2:00 P.M. Dietary				
		d on 1/17/11. The job				
	_	ated she was hired as a				
	•	." The jobs specific				
		ted 1/20/11. The form				
		f member had not				
		ion on all aspects of the				
	•	, including the "food				
	temperature reco	rd."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155727		(X2) MULTIPLE CO  A. BUILDING  B. WING	• NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/16/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 SHAWNEE DR SOUTH BEDFORD, IN47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	provided a log of machine, labeled 3/14/11 at 9:15 A for food tempera and dish machine meals" The form documentation of having been taked meals. The food 1 through the 13-least one meal for provided, 4 of 8 temperatures for been documented. The policy and p 3/15/11 at 10:00 administrator, for "The temperature serving line will recorded at every steam table are in degrees Fahrenher."	the entire day having d.  procedure, provided on A.M. by the facility r temperatures, indicated to of all foods on the be measured and w mealhot foods on the narinated at over 135					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155727 03/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3100 SHAWNEE DR SOUTH STONEBRIDGE HEALTH CAMPUS BEDFORD, IN47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The Dining Service Support F0441 Based on interview, observation and F0441 04/12/2011 employee now has a current TB record review, the facility failed to ensure SS=D skin test. No residents suffered employees of the facility have a current any ill effects from the alleged tuberculosis skin test and/or chest x-ray deficient practice. Completion Date 4-12-2011All residents have for 1 of 8 employees reviewed for the potential to be affected by the tuberculosis testing. Dietary Support alleged deficient practice and Person through alterations in processes and in servicing will ensure Findings include: correct actions to provide a safe. sanitary and comfortable environment and to help prevent On 3/15/11 at 3:30 P.M., the Dining the development and Service Support Person was observed in transmission of disease and the kitchen to be preparing fruit trays for infection.Completion Date 4-12-2011Nurse Managers have the evening meal. been in serviced on TB skin test requirements. Systemic change On 3/15/11 at 4:00 P.M., the Dining the campus will keep a copy of southwest home office support Service Support Person's employee file employee's current TB skin test in was reviewed. The file lacked any a file in the business office. documented PPD skin test since his hire **Completion Date** date of 5/2/05. 4-11-2011ED/designee will complete random audits of home office employees who visit the In an interview with the Business Office campus to ensure TB skin testing Manager, on 3/15/11 at 4:30 P.M., she has been completed and is timely indicated she had contacted the Corporate 5x week x one month then 3x a Office, and she stated no one from the week x one month then weekly thereafter with results of corporate office received an annual PPD. compliance being forwarded to QA committee monthly x 6 The facility policy and procedure for TB months and quarterly thereafter Screening: HCW's [healthcare workers], for review and further suggestions/comments.Completio no date, was provided by the Director of n Date 4-12-2011 Nursing, on 3/16/11 at 9:15 A.M. The policy indicated "The goal of the one or two-step employee surveillance testing for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		155727	A. BUILDING B. WING		03/16/2011		
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE			
STONER	RIDGE HEALTH CA	AMPUS	3100 SHAWNEE DR SOUTH BEDFORD, IN47421				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)		
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG		LISC IDENTIFYING INFORMATION) LIABLY and on hire, is to	TAG	DEFICIENCY)	DATE		
		es who are positive for					
	active disease an	d to promote a living					
		residents and a work					
	environment for contagious	staff that is free from					
	_	lyAdminister to PPD					
		within the anniversary					
	month of hire"						
	3.1-14(t)						

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155727		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			COMPL 03/16/2	ETED	
	ROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH DRD, IN47421	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0000	This state residentia accordance with 41	al finding is cited in	ROO		The submission of this plan correction does not indicate admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality care provided to the residen of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services its residents in an economic and efficient manner. The facility herby maintains it is substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management this facility. It is thus submitted as a matter of state only.	of an of ts	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION	COMPLE	COMPLETED  03/16/2011	
	PROVIDER OR SUPPLIER		STREET 3100 S	FADDRESS, CITY, STATE, ZIP CODE SHAWNEE DR SOUTH ORD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
R0000	This state residentia accordance with 41	al finding is cited in	R0000	The submission of this pleatorrection does not indicadmission by StoneBridg Health Campus that the findings and allegations contained herein are an accurate and true representation of the quacare provided to the residof StoneBridge Health Campus. This facility recognizes its obligation provide legally and medicanecessary care and servicits residents in an econor and efficient manner. The facility herby maintains it substantial compliance with requirements of participation for residenticipation for residenticipation of corrections shall serve as the credibeallegation of compliance all state requirements governing the management this facility. It is thus submitted as a matter of sonly.	ate an e lity of lents to cally ces to nic is in rith al nis on el with	

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AND PLAN	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIEF		A. BUILDING COMP		(X3) DATE S COMPL 03/16/20	ETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	Door Door	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
R0000	This state residentia accordance with 41	_	R00	00	The submission of this plan correction does not indicate admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality care provided to the resident of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services its residents in an economic and efficient manner. The facility herby maintains it is substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of stationly.	of ts y to	

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155727				LDING	ONSTRUCTION	COMPL 03/16/2	ETED
	PROVIDER OR SUPPLIER			3100 S	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH DRD, IN47421		
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R0000	This state residentia accordance with 41	_	ROO	000	The submission of this plan correction does not indicate admission by StoneBridge Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality care provided to the residen of StoneBridge Health Campus. This facility recognizes its obligation to provide legally and medically necessary care and services its residents in an economic and efficient manner. The facility herby maintains it is substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credibel allegation of compliance with all state requirements governing the management this facility. It is thus submitted as a matter of stationly.	of ts y to in	

	IT OF DEFICIENCIES OF CORRECTION	<b>l</b> '		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/16/2011	
	PROVIDER OR SUPPLIER RIDGE HEALTH CA		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH DRD, IN47421		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE	
R0272	record review, the food was prepared conditions, for 1 the facility, in the follow the policy monitoring food temperatures to earn foods served their hands were dirty dishes and staff of clean the juice dispotential to affect who reside within units and received.  1. During the in on 3/14/11 at 9:0 was observed rurthe dishwasher, dishwasher used dishes. She furth temperature should during the rinse of silverware in the had a temperature rinse cycle, the conditions, and the food was observed.	ensure the safety of dishes , staff failed to ensure washed after handling before touching clean lid not know how to spenser. This had the t all 34 of 34 residents in the facilities certified food from the kitchen.  itial tour of the kitchen 0 A.M. Dietary Staff #1, nning dirty dishes through She indicated the hot water to sanitize the	R02	72	Resident A, B, and C, suffered ill effects from the alleged defi practice. Completion Date 4-12-2011All other residents in the potential to be affected by deficient practice and through alterations in process and in servicing will ensure the camp prepares food and serves food sanitary condition. Completion Date 4-12-2011Dietary staff habeen in serviced concerning the chemical sanitizer on the dish washing machine, hand washing machine, hand washing cleaning of the juice machine, food temperatures/thermometicalibration and log book recording. Systemic change the dish machine has been fitted to a chemical sanitizer. Dietary personnel will complete hand washing cmopetency now and annually thereafter. A cleaning log has been inititated to track daily cleaning of the juice machine, and Dietary staff #2 no longer a cook. Completion Date 4-12-2011DFS/designee monitor daily log book for chemical sanitation, food temperatures, and juice machine cleaning log to assure in compliance. DFS/Designee walso observe two random dieta staff preparing food or washing dishes to assure sanitation guidelines followed. These auxill be complete 5x a week for month then 3x week for a morthen weekly with results forwarded to QA committee	cint ave the us d in as ne ng, er ne with g the is will ine dilts ar g ddits	04/12/2011	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION	(X3) DATE S COMPL 03/16/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH PRD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	174 degrees. The removed and plates was then p with the rinse tendegrees. The plates observed to be statistichen.  The maintenance kitchen at 9:10 A mixing valve on on order and had temperatures. He the temperatures had been instruct between loads to temperature reaction.  Dietary staff #1 v provided a log of dishwasher, laber on 3/14/11 at 9:1 areas for food termeals and dishwathree meals. The areas for sanitize sink and cleaning.  The form for 3/1 documented rinse degrees. The log 3/13/11, indicate.	e silverware was ced to dry. A load of blaced in the dishwasher inperature reaching 174 tes and silverware were ored for future use in the  supervisor entered the a.M. and indicated a the hot water heater was been causing the low e indicated he checked each morning and staff ted to wait a few minutes ensure the rinse hed 180 degrees.  was asked for and fremperatures of the led "Daily Data Sheet," 5 A.M. The form had imperatures for all three asher temperatures for all back of the form had r concentration in the g bucket.		TAG	monthly z 6 months and quart thereafter for review and furth suggestions/comments.Comp n Date 4-12-2011	er	DATE

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/16/2011	
		155727	B. WIN			03/16/2	011
	PROVIDER OR SUPPLIER			3100 SH	DDRESS, CITY, STATE, ZIP CODE  HAWNEE DR SOUTH  RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I	· ·- , ··· · · · · · ·		(X5)
PREFIX TAG	(EACH DEFICIEN	TALEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	COMPLETION DATE
	breakfast temper with a rinse temperature for 3/2 and 3/5 were contemperatures 180 3/6/11 document lunch temperature temperatures were 3/8. 3/9/11- lacked lunch or supper to breakfast rinse were degrees, 3/12/11 degrees for the risother temperature or supper from 3/2 documented the 1/180 degrees for the documentation were supper.  The February 20 temperature log in days that were predocumented rinse 1/80 degrees, 11 or provided had at 1/180 degrees degr	ature was documented berature of 175 degrees, or 3/3 were provided, 3/4 inplete with all rinse degrees or above, ed the breakfast and re as 200 degrees, supper re not documented, 3/7, ed documentation of emperatures, 3/10 ras documented at 178 rakfast rinse was 179 breakfast was 168 inse temperature, with no res documented for lunch range of the rinse, no ras completed for lunch range of the rinse, no ras completed for lunch range of the rinse, no range of the 24 range of the 24					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	(X3) DATE S COMPLE	
		155727	A. BUI B. WIN	LDING G		03/16/20	)11
NAME OF F	DROLUBER OR GURRI IER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			3100 SI	HAWNEE DR SOUTH		
	RIDGE HEALTH CA			BEDFO	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710				1/10			DATE
	temperatures and sanitizer concentration will be accurately recorded to ensure						
	l .	of dishes and utensils,"					
	^ ^	nachine temperatures and					
		ration will be recorded					
		wash or rinse cycles					
		not meet the minimum					
	requirements, the	e dining services manager					
	will be notified	if the temperatures do					
	not meet requirer	ments, the cycle will be					
	repeated and tem	peratures observed. If					
		not meet standards,					
		will be takendish					
	_	ture andlogs and					
	· · · · · · · · · · · · · · · · · · ·	orrective action will be					
	kept on file"						
	The dishwasher i	nanufactures product					
	information was	provided on 3/16/11 at					
	10:00 A.M. by th	ne maintenance					
	supervisor, the po	olicy indicated the					
	temperature for t	he rinse cycle should be					
	180 degrees to 19	90 degrees for hot water					
	sanitation to occu	ır.					
	2. Dietary staff	#3 was observed on					
		.M. with a load of dishes					
	in the dishwasher	r. Dietary staff #3					
		perature of the rinse					
	cycle was reaching	ng "almost 180." The					
	load of plates in	the dishwasher was					
	observed to have	a wash temperature of					
	156 degrees and	a final rinse temperature					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155727		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/16/2011		
	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH RD, IN47421	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	the drying rack. observed to rinse gloves or gown of and dishes with the clean plates at Dietary staff #3 ther hands betwee dishes and then the putting them awas the dirty dishes, using the dishwant clean side of the touched clean distorage for future Dietary staff #3 ther hands betwee dishes and the clean distorage for future Dietary staff #3 ther hands betwee dishes and the clean dishes and the clean side of the touched clean distorage for future Dietary staff #3 ther hands betwee dishes and the clean dishes and the clean side of the touched clean distorage for future Dietary staff #3 ther hands betwee dishes and the clean dishes and the clean side of the touched clean distorage for future Dietary staff #3 there are the policy and phandwashing, not the corporate die 3/16/11 at 10:45 employees will the techniques to pre infectionall has entering the Nutt Departmentaft and utensils"	orocedure for o date, was received by etary support person, on a.m. indicated " use proper hand washing event spread of unds are washed when					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	(X3) DATE S COMPLI	
		155727	A. BUI B. WIN			03/16/20	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3100 SI	HAWNEE DR SOUTH		
	RIDGE HEALTH CA			BEDFO	RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		n the dining room on		IAG	,		DAIL
	1 * *	A.M. Dietary staff #2 and					
		10:00 A.M. indicated					
	· ·	re cleaned on the top and					
		ing shift aide, and					
	1	ny came in and cleaned					
		staff # 4 indicated on					
	1	M. the evening shift					
		machines. Dietary staff					
		ide, was interviewed on					
	'	.m. indicated she washed					
	1	chine, the drainage tray					
	_	the kitchen and washed,					
		shed down with the ends					
	of the tubes where	re juice flowed down					
	from the box wip	-					
	_						
	The Cleaning and						
	_	icy provided on 3/15/11					
	at 10:00 A.M. by						
		he policy indicated it had					
		facility on 3/14/11 at					
		policy indicated "daily:					
	1	Remove and wash the					
		, mixing elements, drip					
	1 -	y cover in a mild					
	_	n, rinse thoroughly. 2.					
		el, areas around dispense					
		igerated compartment					
	with a clean, dan	np cloth."					
	During interview	with the Dining Services					
	_	ee, acting as the dietary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727			(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/16/2011	
	PROVIDER OR SUPPLIER	AMPUS	3100 S	ADDRESS, CITY, STATE, ZIP CODE SHAWNEE DR SOUTH DRD, IN47421	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	) BE	(X5) COMPLETION DATE	
	indicated there we dietary staff having He indicated he hapart the day befurther indicated provided the machine. The far provided service 1:30 p.m. which was serviced one last service date  3. During the grat 9:15 A.M. 2 con Resident A and Emeeting indicate chicken that apprevening meal on interview with the Resident C on 3/2 indicated Resided diet, and she had receive the pureed the evening meal family members and told her the control was not done. Somethicken off the treplacements. So tell if the pureed	s/11 at 10:00 A.M., he was no documentation of ing cleaned the machine. That taken the machine was and cleaned it. He the company who chine serviced the cility administrator records on 3/15/11 at indicated juice dispenser we each month, with the of 2/25/11.  Soup meeting on 3/15/11 of the 5 residents, attending the group did they had been served where are are at the Saturday 3/12/11. During an we family member of 15/11 at 9:20 A.M., she and C received a pureed not allowed her to ad chicken on 3/12/11 at 1. She indicated other in the facility had came which can be chicken served on the hall the indicated staff are and took all the rays and provided the indicated she could not chicken was completely took no chances and did					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/16/2011		
		100727	B. WIN		DDRESS, CITY, STATE, ZIP CODE	03/10/2	
NAME OF F	PROVIDER OR SUPPLIER	₹			HAWNEE DR SOUTH		
STONEB	RIDGE HEALTH CA	AMPUS			RD, IN47421		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	not allow her far	nily member to consume					
	it.						
	The week and m	anager, LPN #5, the					
		esidential part of the					
	_	rviewed on 3/14/11 at					
		idicated the chicken					
		imately 5 P.M. at the					
		g on the hall trays					
	appeared underc	ooked. She indicated she					
	immediately stop	pped the chicken from					
	being served to r	residents throughout the					
		ided replacements. LPN					
		and LPN #6 then					
		ken on the steam tables					
	_	oms, she indicated the					
		e lines appeared done and					
		out. During interview 3/16/11 at 10:30 A.M.					
		e had pulled the chicken					
	from all hall tray	•					
	-	is included the one					
	_	ne hall. LPN #6 indicated					
		chicken on the buffet in					
	the dining rooms	s and it appeared to be					
		ndicated she ate a piece to					
		emed fine with it. LPN					
		did not know if a					
	temperature had	been obtained.					
	   Dietary staff # 2	was interviewed on					
	_	A.M. she indicated the					
		ked completely cooked to					
		- <del>-</del>					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155727			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/16/2011	
	PROVIDER OR SUPPLIER		STREET A 3100 S	ADDRESS, CITY, STATE, ZIP CODE HAWNEE DR SOUTH DRD, IN47421	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	it was and did not Dietary staff #2 some of the chicken and it ap Dietary staff #2 manager had beed days to serve as as the cook on 3/2. The Corporate diperson indicated A.M., he had beed chicken and arrive Sunday at 7:00 A he had changed to only staff trained He indicated Dietary staff #2 was hire description indicated "dietary assistant checklist was daindicated the staff received instruction."	could not remember what of record the temperature. Indicated she had used ken to make the purred opeared to be done. Indicated the past dietary on training her for two a cook before she worked (12/11).  Itetary services support on 3/15/11 at 10:00 en called about the yed back at the facility on A.M. He further indicated the schedule to ensure a scooks were cooking. Iterary staff #2 had not been in the facility but was ary aide to assist the cook.  Is employee file was 5/11 at 2:00 P.M. Dietary don 1/17/11. The job ated she was hired as a time to the properties of the interest of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155727			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 03/16/2	LETED
	PROVIDER OR SUPPLIER		3100 S	ADDRESS, CITY, STATE, ZIP CODE SHAWNEE DR SOUTH DRD, IN47421	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	) BE	(X5) COMPLETION DATE
	provided a log of machine, labeled 3/14/11 at 9:15 A for food tempera and dish machine meals" The form documentation of having been taked meals. The food 1 through the 13-least one meal for provided, 4 of 8 temperatures for been documented. The policy and p 3/15/11 at 10:00 administrator, for "The temperature serving line will recorded at every steam table are in degrees Fahrenher.	the entire day having d.  procedure, provided on A.M. by the facility r temperatures, indicated to of all foods on the be measured and w mealhot foods on the narinated at over 135				